Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH DBA INJURY 1 OF DALLAS

Respondent Name
NETHERLANDS INSURANCE CO

MFDR Tracking Number
M4-15-3835-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was approved for Individual Psychotherapy. The service was provided and the claim was denied per EOB precertification/authorization exceeded. CPT Code 90837 was preauthorized, #10828915. Please refer to the attached authorization letter for further review. "

Amount in Dispute: $181.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on July 31, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 6, 2014	CPT Code 90837	$181.46	$181.46

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the medical fee guideline for professional services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 198 – Precertification/authorization exceeded.

Issues

1. Was the dispute date of service denied for exceeding preauthorization?
2. Did the requestor obtain preauthorization for the disputed service?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program." CPT Code 98037 is defined as "Psychotherapy, 60 minutes with patient and/or family member."

2. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."
   The requestor submitted a copy of a preauthorization letter issued by Coventry Workers' Comp Services dated September 15, 2014, preauthorizing 4 visits of individual psychotherapy 1 session per week for 4 weeks, to be completed September 10, 2014 – January 10, 2015. The requestor seeks reimbursement for CPT code 90837 rendered on November 6, 2014. The requestor submitted sufficient documentation to support that the disputed service was preauthorized and rendered within the preauthorized timeframes. 28 Texas Administrative Code §134.600 states in relevant part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." The insurance carrier did not submit documentation to support that the requester exceeded the 4 sessions/ weeks, as a result, reimbursement is determined per 28 Texas Administrative Code §134.203 (c).

3. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications." Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title." The MAR for CPT code 90837 per hour is $201.06 ((55.75 ÷ 35.8228) x 129.19). The requestor seeks $181.46, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $181.46.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $181.46 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 15, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.